

Chapter pre-print. Cite as: Shahvisi, Arianne *Female genital alteration in the UK: a failure of pluralism and intersectionality*. In: Ethical, Legal and Social Aspects of Healthcare for Migrants: Perspectives from the UK and Germany, edited by Katja Kuehlmeier, Corinna Klingler and Richard Huxtable, Routledge (forthcoming).

13. Female genital alteration in the UK: a failure of pluralism and intersectionality

Arianne Shahvisi

13.1 Introduction

In August 2016, a woman was made to remove her swimwear on a beach in Nice, France, as two police officers towered over her seated figure, overseeing her disrobing amid a throng of beach-goers whose exposed flesh was more anodyne in the eyes of the law. Earlier that month, the particular swimsuit variety she was wearing – a ‘burkini’ (portmanteau of burqa and bikini)¹ – had been outlawed by various French seaside resorts, as the clothing was deemed to be a ‘provocation’ (Rubin 2016) which flew in the face of ‘good morals’ (Quinn 2016), and was considered to be symbolic of Islamic extremism (Breedan & Blaise 2016) in the aftermath of a Muslim man having massacred holidaymakers in Cannes earlier that summer. The burkini ban was by no means a marginal political move; it was supported by almost two-thirds of the French population (Pech 2016). Where justifications were ventured, the dominant rhetoric was one of alleged concern for the well-being of burkini-clad women. Commentators claimed to apprehend the swimwear as a visible manifestation of the patriarchal subjugation of Muslim women, who were deemed to have the right, or perhaps the obligation, to engage in similar levels of nakedness to other women on the beach.

It is my contention that accepting this interpretation at face value is unduly charitable; there is no compelling reason to believe that resistance to the burkini stemmed from concern about the welfare of Muslim women. For one, the immediate effect was to produce an atmosphere of fear and exclusion, within which Muslim women’s bodies became a criminalised spectacle and were unsurprisingly and understandably more likely to avoid beaches than to embrace a newfound affinity for the bikini. Rather, the concern about the burkini was a sign of the cracked

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mask of multiculturalism, a product of rising Islamophobia within French society and across Europe (Ogan et al. 2014).

Similarly, I think we should be concerned about responses to female genital alteration (FGA) within the UK. Again, the primary stated reason for opposition to the practice is that it enacts patriarchal control against female bodies and is framed as child abuse and violence against women and girls (HM Government 2016, p. 4). Draconian legislation around FGA appears to be designed to respond to a growing public appetite for punitive measures towards incursions against ‘British values’ (Dustin & Phillips 2008), regardless of the effect on the women it claims to protect. Of course, this analogy is not intended to be perfect. The burkini ban was never legally enshrined (unlike the passing of the ‘Act prohibiting concealment of the face in public space’ in France just six years before) and was the result of long-standing resentments being brought to a head by a particular incident, while FGA legislation in the UK is the result of a protracted political debate over many decades. However, the similarities are significant. Both are concerned with choices women make, or are perhaps compelled to make, about their bodies in the realm of the intimate and sexual: that of swimwear and genitals. In neither case are women believed to be capable of making that decision for themselves, and in both cases the choice of ‘Western’ women is deemed to be superior without justification. The burkini debacle may have been short-lived, but by the light of its momentary flare, a good deal could be learned about anxieties regarding the threat of the ‘Other’ and the sense of cultural superiority that continues to characterise modern Europe, and the way in which these factors shape the debate around FGA.

In this article, I wish to show that legislation around FGA bears some important parallels to policy around the burkini. Neither is properly understood as motivated by serving the best interests of the women in question. Rather, both are motivated by, at best, an overly simplistic

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and poorly informed desire for gender equality which ignores intersectionality, or, at worst, deeply ingrained cultures of racism and sexism. Both have gained traction in public discourse because their racism is easily concealed within ostensible concern about the well-being of women of colour. Both fail to engage meaningfully with cultural pluralism, resulting in inconsistencies which point towards ethnocentrism.

The rise of nationalism and the increasing hubris of racist public discourses across Europe and the US makes this discussion particularly urgent. Penalising the practices of marginalised people is as unlikely to result in social cohesion as it is to promote abandonment of those practices and renders marginalised people simultaneously more visible—in the sense of becoming criminalised—and more *invisible*, in the indirect sense of being less likely to have their perspectives heard, and directly, in the sense of having good reason to take measures to avoid state surveillance.

Within this chapter, I endeavour to refer to the practice in question as ‘female genital *alteration*’ (FGA), rather than the more common ‘female genital *mutilation*’ (FGM). No community practising FGA describes the act as mutilation, and the word signals a strong negative value which prescribes a particular moral tone prior to any ethical analysis. Further, the breadth of its usage seems to reflect the unexamined racism and ethnocentrism which are commonly noted within these discourses (c.f. Ahmadu 2016). To make the complexities vivid, one might reasonably argue that genital alterations are best understood as mutilation when performed on the healthy tissue of *children*, who necessarily cannot consent, but that another term would be more apt when speaking of adults. By corollary, male circumcision in infants would then be better described as male genital mutilation. In order to avoid foreshadowing these complex discussions at the outset, I refer to FGA in place of FGM, and speak of female cosmetic genital surgeries (FCGS) and male circumcision.

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My discussion of FGA will centre on the practice as requested by and performed upon *adult* women. One cannot focus on the practice as applied to legal minors without inevitably being drawn into a discussion about the ethics of male circumcision, which would divert my attention here. I refer the reader to other work within which I clarify my sex-neutral position on genital alterations for minors (Shahvisi 2016a). That said, it *is* important to acknowledge that the fact that FGA is in many cultures performed on minors who cannot consent is core to the widespread resistance to the practice and is therefore an important context to bear in mind when reading what follows. Current legislation in the UK was intended primarily to protect children, and the child protection framing is undeniably a determinative backdrop to the emotive public discourse around FGA which has been key in motivating the legislation. However, were child protection straightforwardly the sole or primary factor influencing discourse, we would expect similar outrage around male circumcision and concomitant legislation. I bracket this debate in this chapter and instead focus on adult women, and the discursive framework that surrounds their access to, and relationship to, FGA, as this makes space to focus on social discourses other than the comparatively uncontroversial child protection agenda.

The chapter is structured as follows. In Section 13.2, I introduce the legislation around FGA in the UK, and interpret its inconsistencies within the broader social and political context. In Section 13.3, I interrogate the terms ‘ritual’ and ‘custom’ as included within the legislation and describe the way in which discourses and legislation around FGM (and the burkini) fail to take into account cultural relativism. In Section 13.4, I rehearse the idea of intersectionality, describe the positionality of the women affected by FGA legislation, and argue that if taken seriously, the claim that banning FGA and the burkini is helpful amounts to a failure of intersectionality. Section 13.5 concludes this chapter.

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13.2 Female genital alteration in the UK

Many varieties of non-medical genital alteration are practised in the UK. Female cosmetic genital surgeries are used to reshape, and reduce the size of, the clitoris and labia; female and male genitals are pierced; the foreskin of penises is removed in infant males in order to adhere to religious requirements within Islam and Judaism; and female genitalia are modified in accordance with customs prevalent in some regions of Africa, the Middle-East and South-East Asia. All of these modifications are legal, even in minors, except the last, which is illegal even for consenting adults.

In England, Wales and Northern Ireland, FGM is legislated against via the FGM Act 2003, according to which ‘for a person to excise, infibulate, or otherwise mutilate any part of a girl’s labia minora, majora or clitoris’ is an offense carrying a sentence of up to 14 years. Definition 6(1) of the Act states that ‘Girl includes woman,’ which means that the terms of the Act apply to adult women just as they do to children, despite the different consent capacities of these groups in almost all other circumstances. A functionally identical piece of legislation applies in Scotland – Prohibition of Female Genital Mutilation (Scotland) Act 2005 – with the same maximum sentence, but without this worrying clause (I therefore refer to ‘UK legislation’, except when stated otherwise).

The existence of these dedicated pieces of legislation is itself noteworthy, given that there is no legislation to protect against any of the other non-medical genital alterations just mentioned. A wide literature has unfolded over the last two decades with regard to the hypocrisy presented by the inconsistencies in legislation. If removing the tissue of a small child is so obviously egregious, why is male circumcision so widely legal? If modifying the genitals of an adult woman is so concerning, why is female cosmetic genital surgery permissible even when the tissue removal is identical? I will not consider these questions in detail here, but instead refer

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the reader to works that tackle these hypocrisies directly (Dustin 2010; Earp 2016; Ehrenreich & Barr 2005; Johnsdotter & Essén 2010; Shahvisi 2016b; Sheldon & Wilkinson 1998).

There are other aspects of the FGM Act that provoke specific concern, and these will form the focus of this section. Consider the following extract from the Act, which caveats the illegality of genital alterations in females:

(2) But no offence is committed by an approved person who performs

(a) a surgical operation on a girl which is necessary for her physical or *mental* health [...]

(5) For the purpose of determining whether an operation is necessary for the mental health of a girl *it is immaterial whether she or any other person believes that the operation is required as a matter of custom or ritual* (FGM Act 2003, Section 1, my italicised emphasis).

This needs some unpacking. We are told that genital alterations, whilst generally an offence, *can* be performed for reasons of physical health. This means, for example, that a person with a malignant vulvar growth can undergo surgery within the law; equally, a patient with abnormally long labia, causing irritation with movement or from clothing, is able to obtain a reductive labiaplasty. These cases seem straightforward.

We are also told that genital alterations can take place in response to mental health needs. In other words, the clitoris or labia can be altered in cases in which doing so is deemed to be beneficial to the mental health of the patient. Cosmetic genital surgeries are offered within standard National Health Service (NHS) treatment for these purposes and are occurring in increasing numbers. These procedures generally consist of cliteridectomy and/or labiaplasty.

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Note that these procedures are core elements of FGA as practised for reasons of custom or ritual.²

In the years 2010–2011, 1726 labiaplasties took place within the NHS (Health and Social Care Information Centre 2012), and there is reason to believe that a greater number still occurred in the private health sector, where most cosmetic procedures are performed. A fivefold increase in the number of requests for labiaplasty was recorded in the UK between 2001 and 2008 (Runacres et al. 2015). This is despite the fact that studies have found that the labia of women requesting reductions via labiaplasty have been found to be within normal limits (Crouch et al. 2011). In addition, 2105 labiaplasties were performed on children under the age of 15 years in the period 2005–2016 (*ibid.*). Note that *adult* women cannot consent to FGA within the law.

There has been a paucity of research into the psychology of requests for cosmetic genital surgeries, but interestingly, an empirical study (Veale et al. 2014) examining those requesting labiaplasty did not demonstrate any increased depression or anxiety-related psychopathology with respect to controls. Further, less than 20% of those in the study group satisfied diagnostic criteria for body dysmorphic disorder. The common thread was instead a general dissatisfaction with the appearance of the genital area, a strongly held genital aesthetic ideal, and a subsequent reported reduction in quality of life when ideal and reality are perceived not to meet. In a detailed case study (Veale & Daniels 2012), a woman requesting clitoridectomy (having already undergone labiaplasty) was deemed to have no psychiatric or personality disorder. She reported low quality of life in relation to her (medically normal) genitalia due to holding very specific aesthetic standards, by her own admission. She was able to undergo the procedure regardless.

In other words, there is no compelling case that those requesting cosmetic genital surgeries for reasons of mental health have either (a) statistically abnormal genitals, or (b) poor psychiatric

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health. Rather, there is evidence that women requesting labial and clitoral reshaping and reduction do so purely for aesthetic reasons, under the pressure of conformity to particular genital ideals. Even if there *were* more evidence for poor mental health amongst these patients, it is not clear that carrying out genital modifications on healthy tissue would be helpful in tackling the root problem. This is not to criticise the implementation of the procedures *per se*, but to suggest that it is dishonest to describe them as medically indicated.

Sudanese surgeon (and anti-FGA activist) Nahid Toubia describes the bafflement and resentment of women of FGM-prevalent communities when they ‘look at the Western world and see women undergoing their own feminization rites intended to increase sexual desirability’ (Toubia 1995, p. 232, paraphrased within Sheldon & Wilkinson 1998, p. 264). This hypocrisy is particularly evident since the ideals pursued by women seeking FCGS originate in pornography (Braun 2005, p. 413; Essén & Johnsdotter 2004, p. 612; Iglesia 2012) and are therefore bound up with other debates about the sexualisation of female bodies.

Dustin (2010, pp. 15–16) discusses the role of the powerful medical lobby in ensuring a caveat in the legislation in order that surgeons could continue to practice the (highly lucrative) work of cosmetically modifying female genitals. One wonders whether yet another parallel might be drawn with FGA, where an employment sector of ‘cutters’ has developed in symbiosis with the practice (Mgbako et al. 2010), providing an economic basis for its continuation. In a debate in the House of Commons in 1985, Conservative MP Marion Roe noted that FGA legislation must not interfere with a ‘patient’s right to receive legitimate or ethical surgery’, (*Prohibition of female circumcision bill 1985* (UK Parliament)) which remains undefined. In the same debate, Labour MP Jo Richardson worries that the mental health clause

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could be considered to have racial overtones as it forbids the use of mental stress as a reason for those who wish to have female circumcision for ritual or custom as against those who use mental stress as a reason because of difficulties with deformed or enlarged genitalia [...] However, I have been unable to find any other way of changing it.

(*ibid.*)

Evidently, she was not alone in her lack of imagination (or perhaps she was alone in her reservations), as the clause survives into current legislation.

Clearly, there is a double standard at work in the legislation, which states that certain procedures *can* be performed in order to service the aesthetic needs (as mandated by particular norms) of certain groups but cannot be performed in order to meet the (culturally mandated) preferences of other groups. This is a strange twist, given that the ability to consent to a procedure when one is suffering from reduced mental health is typically diminished, rather than privileged for that reason. This oddity, and the racism it contains, is lost on many. Psychiatrist David Veale defends the illegality of one and not the other, noting that the

spirit of the legislation sought was to remove the barbaric [sic] practice of female genital mutilation based on custom. I do not think legislators were able to anticipate the demand for cosmetic surgery where the subject's motivation is to reduce self-consciousness, discomfort or enhance sexuality.

(2013, p. 325)

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One obvious response to this double standard is the claim that FGA entails severe health risks. It is true that FGA can cause health issues both in the short-term—including pain, infection, haemorrhage, and, in extreme cases, death—and in the long-term—problems with urination, sexual pleasure, menstruation, infections and obstetric difficulties (British Medical Association 2011, p. 4). Yet several points must be noted: first these outcomes are often worst case scenarios rather than typical effects (Dustin 2010, p. 9); second, there are many varieties of FGA, ranging from a mere ‘nick’ to full excision, and the effects of these vary enormously, and are rarely separated out (see, e.g., Shahvisi 2016a; Dustin 2010, p. 9); third, many of these issues are associated with the conditions under which the procedure is performed (e.g., an unsanitary environment and non-surgical instruments), which could be reduced by medicalisation. This last point is arguably most important: the most notable difference between labiaplasty in an FGA context and a FCGS context is that one is performed by an expert clinician in a clinical setting with clinical instruments, and the other is not. As such, one would expect infection and complications to be minimal in one and not the other. Regardless, FCGS also entails complications. Excessive post-operative bleeding, dyspareunia, healing issues, adhesion, infection and reduction in sexual satisfaction are all commonly noted (Committee on Gynecologic Practice 2007; Goodman et al. 2009, pp. 1571–1572).

13.3 Ritual, custom, and cultural relativism

One can rephrase UK legislation while maintaining its sense, to proclaim that alterations to female genitals for reasons of ‘custom or ritual’ are forbidden, while all other cases are permissible. In 1983, Lord Kennet assured the House of Lords that FGA ‘is without any religious justification anywhere in the world, including the countries where it is endemic. It is a customary practice and no more’ (*Prohibition of female circumcision bill (H.L.) 1983* (UK

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Parliament)). One wonders what the fate of the practice would be if it *were* religiously mandated, and how this hierarchy of justifiable reasons is itself justified.

In order to make better sense of this, ‘custom’ and ‘ritual’ must be defined and distinguished. The legislation itself remains silent on the meanings of these terms, but they are well-defined elsewhere. Anthropologists define custom as

Habitual practices of an individual or culture, the traditional way of doing things or thinking about them, as passed down the generations. Custom is learned but often erroneously perceived as “natural,” and affects decisions regarding all areas of social life.

(Morris & Morris 2012, p. 59)

Ritual is defined as a ‘formal, often religious, set of practices characterized by themes of celebration, renewal, or affirmation. Actions performed in ritual often have symbolic meaning. [...] Ritual can be seen as strengthening the status quo’ (*ibid.*, p. 219).

Three questions arise. First, is FGA rightly classified as being motivated by ritual and/or custom? Second, is female cosmetic genital surgery rightly understood as being motivated by ritual and/or custom? Third, what is it about rituals and customs that renders them unfit to be motivations for consensual actions?

To answer the first question, it seems fairly uncontroversial to describe FGA as both customary and ritualistic. It is an important part of the culture of those who follow the practice and is usually performed as ritual entry into the community, or to adulthood within that community. Motivations for FGA, like the practice itself, are incredibly varied (Lyons 2007). As with male circumcision, reasons include, for example, purported health benefits, hygiene, aesthetics,

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looking like other adults within the community, reduction of promiscuity and sexual attractiveness (Svoboda 2013, p. 244). One notable motivation for FGA is the feminisation of the genitals. The clitoris is seen by some groups as a vestigial penis, and its removal permits the fulfilment of female identity (Shweder 2000, p. 219). FGA is therefore part of the creation of the female sex and of the reinforcement of the sex binary.

As for the second question, it is now axiomatic to describe gender as a dynamic process of continual collaborative construction, impelled by social pressure, rather than a static, essential property of what fe/male bodies can do or be in the world. The performativity of gender (Butler 1990), widely understood as an accurate and edifying evocation of the construction and perpetuation of gender, provides a ready template for understanding gender across cultures as a ritual that is collectively undertaken to renew and affirm the reality of the binary. Both sex and gender are daily created. Gender is created by what one does with one's body, for example, particular bodily comportments and clothing. Sex is created by what one makes one's body *be*, that is: modifications to bodies which accentuate sex dimorphism, that is, males are encouraged to cultivate musculature, females are required to remove body hair and disregard their calorie needs.

With this in mind, just as FGA is seen as a ritual which feminises genitals and produces the sex binary, so too might FCGS be seen as a ritual (amongst others) which permits one to achieve the 'ideal' female body, largely for reasons of (perceived) acceptability within the sexual world. While it may not be accurate to call FCGS customary, since despite its growing popularity it is still a marginal procedure, it falls squarely into a category of modifications to the female body (selective hair removal, make-up, dieting) that *are* customary within many cultures, and are performed repetitively, *ritualistically*, as ways of maintaining membership within the tribe of

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the normative female/feminine, under undeniably patriarchal conditions. As such, the distinction made in section 5 of the FGM Act is baffling.

One might argue that the point about FCGS not being customary deserves greater consideration. Where FGA is performed, prevalence rates generally exceed 80% and within specific communities can reach 100% (UNICEF 2005). FCGS is performed by a small minority of women in the UK. One could say that what is different (and wrong) about FGA is that it is *necessary* for adult women, while FCGS is not. This has some force. But it seems counter-intuitive that something that is not very important to the people of one culture should be more permissible than something that is deemed essential to people within another culture. In other words, a woman requesting FGA would likely have a greater desire for the procedure than a woman requesting FCGS, and more to lose if the procedure were not performed (including in mental health terms!), yet *she* would be denied it.

Turning to the third question: what is it about 'ritual or custom' which renders them inadequate bases to be motivations for consensual actions? An obvious response is that rituals are undertaken in order to conform to social norms, in which case, the consent is not optimally voluntary. As such, it is the norm that forms the basis for, and force behind, the practice, rather than the consent of the individual. Yet this is to ignore the function and logic that underwrites rituals, which are not performed (only) to avoid social penalty but to bring about specific, desired changes, that is, to remove genital components that are considered to be male, to achieve a more attractive appearance, or to reduce sexual desire etc. To paint those performing rituals as blindly following orders is to present them as Other, the colonial subaltern, for whose actions no logic should be expected or sought. This misrepresentation is not benign but may be seen in Foucauldian terms as engineered to serve the ends of particular sites of social power,

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and to justify neo-colonial discourses about cultural superiority (c.f. Foucault 1990). This is important because

everything turns on who counts as a fellow human being, as a rational agent in the only relevant sense – the sense in which rational agency is synonymous with membership of our moral community.

(Rorty 1993, p. 124)

In other words, representing rituals as irrational, and describing only select cultures as following rituals, is a way of marginalising those people within the moral community, and excluding their values from those which must be collectively negotiated and accommodated. It is a form of ethnocentrism which views European culture, and European patriarchy, as so natural and superior as to be beyond critique. Unsurprisingly, this racism is evident throughout the political debate which forms the legislation. Consider the following comments, made by Baroness Gaitskell in the House of Lords in 1983:

It is, after all, enough that women from other countries can come and live in ours.

We are doing very well by them in allowing them to live in this country. It is nice for them and it is nice of us to do it. But we do not have to import their kind of rules. The point is that such people are not in a position to teach us anything about sexual behaviour. What have they to teach us about intimate sexual matters?

Absolutely nothing.

(Prohibition of female circumcision bill (H.L.) 1983 (UK Parliament))

13.4 A failure of intersectionality

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In the case of the burkini and the case of FGM, we are asked to believe that those opposed to these practices are attempting to defend the human rights of the women and girls concerned. In other words, resistance to FGM and Islamic dress is intended to resist the patriarchal norms that perpetuate these practices. Yet it is not clear that the norms are always patriarchal, and it is even less clear that this is the foremost concern for those who enact such vehement opposition, since their concern for the well-being of women does not generally extend to other issues, or to other areas of the same women's lives.

As Shweder points out (2000, p. 221), FGA is not a good example of the oppression of women and girls via control over female bodies, since more or less all societies which customarily perform FGA also perform male circumcision, while there are many cultures within which genital alterations are *only* performed upon males (consider Judaism, Islam, for the most part, and the culture of male genital alteration in the US). In most cultures with high prevalence of FGA, genital alterations are performed upon both sexes as intentionally equivalent initiation rites into adulthood. While FGA is often described as being intended to control and limit the sexuality of women, male circumcision is rarely described in this way, even though it has been shown to limit the sexual pleasure of men (Taves 2002). Further, FGA is almost exclusively discussed, performed and celebrated within women-only spaces, and there are examples of women defying the men of their communities in order to perform the practice (c.f. Thomas 1996), and young girls pursuing the practice while adults of all genders within their community repudiate it (c.f. Leonard 2000).

However, for the purposes of this section, let us assume that FGM is performed for reasons that *are* broadly patriarchal, and that critics' objection to the practice is authentically driven by this. After all, it is hard to explain away that fact that (say) a recent ethnography in Egypt, which has one of the highest prevalence rates of FGM globally, found that the principal motivation

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for performing clitoridectomy is ‘to reduce and regulate girls’ and women’s sexual desires and sexual drive’ (Fahmy, El-Mouelhy & Ragab 2010, p. 184). Even if one concedes that FGA is more generally an instance of the control of female bodies or sexuality, banning the practice would not necessarily be an appropriate response, either from a moral or a pragmatic position. In order to see this more clearly, consider the idea of intersectionality within feminist theory. Coined by black legal scholar Kimberlé Crenshaw (1991), ‘intersectionality’ builds on an operative concept dating back more than a century, originating in the work of black feminists who recognised that the struggle for women’s rights as an isolated cause would not be effective in attenuating the oppression of women of colour (c.f. Combahee River Collective 1983). Intersectionality emphasises that different forms of oppression interact with one another in complicated ways, so that feminists should not only be concerned with the oppression of women, who are manifestly not a homogeneous group, but should be concerned with how (say) racism, classism, homophobia and ableism jointly determine the experiences of women in ways that cannot be predicted simply by notionally combining these oppressions. Combating the oppression of any given group of women requires assiduous engagement with other pertinent marginal identities. This requires careful consideration of the positionality of the individual under question.

Those affected by FGA in the UK are women of colour who are asylum seekers, refugees, economic migrants (with or without documentation), or daughters or granddaughters thereof. Across the UK, there are over 86,000 first generation migrant women and girls who have experienced FGA in their countries of origin (Read 1998) and with rising numbers of asylum seekers arriving from Sierra Leone, Somalia and Sudan, each of which has a prevalence of FGA exceeding 88% (UNICEF 2016); the numbers of women in the UK affected by FGA is rising. A study based in South London noted that around 40% of those affected by FGA spoke

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little or no English (Momoh et al. 2001, p. 187). Further, while FGA is *not* an Islamic practice according to scripture (e.g., Rouzi 2013), many of those migrating to the UK from FGA-prevalent contexts are Muslims from Muslim majority countries where FGA is practised as a religious custom.

In other words, those who practice FGA are women, people of colour, often Muslims, migrants, refugees or asylum seekers, and may speak very little English. All of these factors are sources of significant vulnerability within the UK in the present context. Further, in the wake of increased scrutiny and complication around migrants using the NHS (Farrington et al. 2016), and new mandatory reporting and recording responsibilities for healthcare professionals regarding FGA (Amasanti, Imcha & Momoh 2016), those from FGA prevalent groups are likely to be further marginalised within healthcare settings. Data shows that migrants in general underuse health services (Steventon & Bardsley 2011) and have worse health outcomes (Jayaweera 2014; Raphaely & O'Moore 2010) with the current political climate raising particular concerns about health outcomes for Muslims in the UK (Laird et al. 2007).

Analyses of FGA tend to ignore, silence, or overwrite the lived experiences of the women of FGA-practising communities. Ahmadu criticises the way in which Western discourses on FGA tend to fixedly 'gaze between the legs of circumcised African women, rendering them "invisible" as individuals with their own dynamic histories, cultures, and traditions' (2007, p. 279). In particular, the vulnerabilities just mentioned are rarely foregrounded in discussions of FGA, even though it is likely that the threat and actuality of FGA to women of practising communities is likely less menacing than the threat and actuality of racism and social exclusion. The criminalisation of FGA disregards the multiple interlocking vulnerabilities experienced by the women who are targeted by the legislation. People of colour, women of colour and even more so, *Muslim* women of colour, are made conspicuous and vulnerable by rising levels of

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racism within UK society. As Fernando points out ‘police brutality and state racism are issues of everyday concern to Muslim and minority women, and therefore feminist issues’ (Fernando 2016, p. 45). In the case of the burkini and FGA, the police are called upon to criminalise the body choices of consenting adult women, and state apparatus is called upon to codify racism into law. These are bans upon the ordinary lives of certain women, who are constrained by notions of criminality conveyed to them from outside their own culture to avoid sites of everyday existence (beaches and health services) in order to avoid being confronted by the violence of that criminalisation.

If one views FGA as a patriarchal restriction on the lives of women, to place additional restrictions on those lives through the threat of state violence seems no different to imposing bans on beachwear whose most likely outcome is the women in question remaining at home, debarred from public life by the joint effect of their own ‘outsider’ culture conspiring with the ‘insider’ culture to diminish possibilities for public participation which could offset the effects of racism and sexism. Bans on FGA and the burkini seem to follow the same farcical logic: criminalising the ‘barbarism’ of the act is given primacy over the welfare of those affected by the act; the vilification of the act and its symbolism trumps the rights of the people involved. This brings to mind colonial ‘civilising missions,’ and seems just as disingenuous.

This debate is a special case of a broader philosophical question about how to reify agency and understand its operation within the confines of the social world. The feminist literature on body modifications is instructive in this regard. Davis (1991) explores the concept of agency in relation to cosmetic surgery, asking how feminists should understand women's decisions to modify their bodies in response to patriarchal ideals. She recommends a feminist re-articulation of agency, which casts women as informed actors, and respects constrained choices as choices

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nonetheless. This is in spite of, and often in the awareness of, the fact that these decisions, like so many others, are harmful to women as individuals and as a whole. She contends that

it is possible to view women who willingly choose and retrospectively defend cosmetic surgery for themselves as knowing what they are doing. Their decision may be a knowledgeable and rational one, even as it reproduces a complex of power structures that construct the female body as inferior and in need of change.

(*ibid.*, p. 33)

So too must we recognise that one cannot ‘save’ women from the patriarchal aspects of FGA by beginning with the deeply problematic assumption of their lack of agency and proceeding with indifference to the many other constraints on their existence. One such constraint is racism, which is, either by accident or design, apparent in the double standard in the legislation. To fail to see an entire group of people as anything other than ‘victims’ of FGA, and to see fit to *punish* them for that, is a failure of intersectionality.

13.5 Conclusion

There has been a recent rise in nationalist populism across Europe, characterised by the perception of a ‘civilizational threat’ (Brubaker 2017, p. 3) posed by Islam, immigration, asylum seekers and the demand for multiculturalism and tolerance, which has fomented to a staunch secularism which professes to privilege gender equality, LGBT rights, and the right to freedom of expression, as these are believed to be antithetical to the values of Islam. It is against this backdrop that those supporting the banning of FGA and the burkini claim to be acting in the best interests of women, and it is precisely because of that context that we should be

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suspicious of their claims. Even where concerns about the social meanings of FGA and the burkini are not disingenuous, banning these practices constitutes a failure of intersectionality, as it ignores the lived experience and subjugates the agency of those subscribing to these cultural practices.

In the case of FGA and the burkini, the intimate world of women is deemed to be a threat to Western culture. Both bans are bound up with ideals about the presentation of the female body. Opposing the burkini, which broke no French laws outside of the beach context, was just as much about promoting the bikini, and other forms of swimwear which expose the female body. As such the opposition was centred on the idea of the unclothed female body and its relationship to female sexuality. Opposing FGA, which breaks no UK laws when equivalent practices are described as FCGS, is a way of suggesting that particular women's body ideals are more acceptable than other women's body ideals, even if the realisation of those ideals is essentially the same.

To finish, I suggest that policy-makers and interlocutors in these debates consider FGA in its rightful place: as part of an intelligent, sensitive and collaborative dialogue about cultural pluralism and intersectionality that is led by migrant women of FGA-prevalent communities, without fear of judgement or reprisal. To be swayed by the tide of populist sensationalism at a time when tolerance is needed more than ever is to commit particular groups to fear, danger and dehumanisation. After all:

Tolerance means setting aside our readily aroused and powerfully negative feelings about the practices of immigrant minority groups long enough to get the facts straight and engage the “other” in a serious moral dialogue. It should take far more

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than overheated rhetoric and offended sensibilities to justify a cultural
“eradication” campaign.

(Shweder 2000, p. 227)

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¹ This is an inaccurate descriptor, but I use it here to be consistent with the wider literature. The burkini is a loose, but fitted, whole body swimsuit (often in two parts) with an in-built hood, akin to a sports hijab; a burqa is shapeless whole-body covering whose defining feature is a face-veil. 'Burkini' seems an apt term due to its closeness to 'bikini', but its inaccuracy only adds to the homogenising of varied Muslim practices and beliefs, and the sensationalising of this swimwear choice given the controversial relationship the French state has to the burqa.

² Note that only 10% of women who undergo FGA endure the most extreme kind of alteration, 'infibulation', in which the clitoris and labia minora are excised, and the vulva sewn together, leaving only a small opening for urine and menstrual blood (Yoder & Khan 2008, 15).